| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 07/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K0000 | A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 07/02/12<br><br>Facility Number: 000029<br>Provider Number: 155072<br>AIM Number: 100275200<br><br>Surveyor: Mark Caraher, Life Safety Code Specialist<br><br>At this Life Safety Code survey, Beech Grove Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility with a partial basement was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridor. The facility | K0000 | The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.<br><br>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after July 31, 2012. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 132 and had a census of 119 at the time of this survey.<br><br>The facility was found not in compliance with state law in regard to sprinkler coverage and smoke detector coverage.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/09/12.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: | | | |

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| K0046 SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.<br>1. Based on record review, observation and interview; the facility failed to document monthly and annual testing of emergency lighting in accordance with LSC 7.9 for 13 of 13 battery powered emergency lights for 12 of 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals and an annual test be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the facility.<br><br>Findings include:<br><br>Based on record review with the Environmental Supervisor from 9:50 a.m. to 11:30 a.m. on 07/02/12, documentation of 30 day interval testing and an annual test of all thirteen battery powered emergency lights in the facility was not available for review. Based on interview | K0046 | K046 NFPA 101 Life Safety Code standard<br><br>It is the practice of this facility to ensure that the documentation is completed monthly and annually for the emergency lighting system in accordance with LSC 7.9.<br><br>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?<br><br>There were no residents cited in regard to this regulation.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>Facility documentation for battery powered emergency lighting is implemented and completed | 07/31/2012 |

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| | at the time of record review, the Environmental Supervisor acknowledged no documentation of 30 day interval and annual testing of each battery powered emergency light was available for review. Based on observations with the Environmental Supervisor during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 07/02/12, thirteen battery powered emergency lights were observed in the facility.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 5 of 13 battery operated emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Environmental Supervisor during a tour | | monthly and annually in accordance with LSC 7.9<br><br>What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br><br>Facility will follow facility preventative maintenance manual.<br><br>Log implemented to complete and document test to test the lighting for 1.5 hours in duration annually and checked for operation every 30 days.<br><br>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>An audit of the log will be reviewed by the Executive Director monthly.<br><br>Compliance Date: 7/31/12 | |

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| | of the facility from 11:30 a.m. to 2:15 p.m. on 07/02/12, the battery operated emergency light at the Therapy exit and the four battery operated emergency lights inside the weather shell at the emergency generator each failed to illuminate when the test button was pressed five times. Based on interview at the time of observation, the Environmental Supervisor acknowledged the battery operated emergency lights at the aforementioned locations each failed to illuminate when the test button was pressed five times.<br><br>3.1-19(b) | | | |

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| K0050 SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br>Based on record review and interview, the facility failed to document fire drills conducted on the first, second and third shifts for 2 of 4 quarters. This deficient practice affects all occupants in the facility.<br><br>Findings include:<br><br>Based on review of "Monthly Fire Drill Report" documentation with the Environmental Supervisor during record review from 9:50 a.m. to 11:30 a.m. on 07/02/12, there is no documentation available for review of a fire drill conducted on the first, second and third shifts for the third and fourth quarters of 2011. Based on interview at the time of record review, the Environmental Supervisor acknowledged, there was no documentation available for review of a fire drill being conducted on the first, second and third shifts for the third and | K0050 | K050 NFPA 101 Life Safety Code Standard<br><br>It is the policy of this facility to have fire drills that are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 pm and 6 am a coded announcement may be used instead of audible alarms.<br><br>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice? | 07/31/2012 |

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| | fourth quarter of 2011.<br><br>3.1-19(b) | | There were no residents cited in regard to this regulation.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents, staff and visitors have the potential to be affected by the alleged deficient practice.<br><br>What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br><br>The maintenance director will document more extensively the conditions of the each fire drill conducted and the type of fire that is being drilled. The times of the drills will be varied.<br><br>A log will maintained to document the completion of the drills. | |

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| | | | How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>The Executive Director or designee will review and sign off on the fire drill report monthly, as provided by the maintenance department. Any findings will be reviewed by the CQI committee and action plans are developed to improve performance, which may include reeducation and/or disciplinary action.<br><br>Compliance Date: 7/31/12 | |

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| K0051 SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station.<br>19.3.4, 9.6<br>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors in the facility.<br><br>Findings include:<br><br>Based on observation with the Administrator and the Environmental | K0051 | K051 NFPA 101 Life Safety Code Standard<br><br>It is the practice of this provider to have a fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 72. The system has approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72.<br><br>What corrective action(s) will be accomplished for those resident | 07/31/2012 |

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| | Supervisor during the tour of the facility on 07/02/12 from 11:30 p.m. to 2:15 p.m., when the DACT primary telephone line was disconnected at 1:32 p.m. the facility's fire alarm system failed to failed to annunciate a trouble signal locally. The facility's fire alarm system annunciated a trouble signal in the electrical room annex to the basement laundry room. Based on interview at the time of observation, the Administrator stated the laundry room is not staffed continuously over each shift each day and acknowledged the facility's fire alarm system did not annunciate a trouble signal where it was likely to be heard at all times.<br><br>3.1-19(b) | | found to have been affected by the deficient practice?<br><br>There were no residents cited in regard to this regulation.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents, staff and visitors have the potential to be affected by the alleged deficient practice.<br><br>What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br><br>The primary telephone line for the for the facility fire alarm system will be connected at all times.<br><br>The facility fire alarm will annunciate in a location where staff are present at all times. | |

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| | | | How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>An environmental CQI tool will be utilized weekly x 4 and monthly thereafter to monitor compliance with emergency lighting. The audits are reviewed by the CQI committee and action plans are developed to improve performance, which may include reeducation and/or disciplinary action.<br><br>Compliance Date: 7/31/12 | |

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| K0056 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>Based on observation and interview, the facility failed to ensure a sprinkler head was installed in 1 of 1 elevator rooms and in 1 of 1 Activities Room closets to provide coverage for all portions of the building. NFPA 13 at 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. This deficient practice could affect residents, staff and visitors in the vicinity of the Elevator Machine Room in the basement and in the vicinity of the Actives Room closet.<br><br>Findings include:<br><br>Based on observation with the Environmental Supervisor during the tour of the facility on 07/02/12 from 11:30 p.m. to 2:15 p.m., the Elevator Machine Room in the basement and the Activities | K0056 | K056 NFPA 101 Life Safety Code Standard<br><br>It is the policy of the facility that all required sprinkler heads, including those in the activities room closets and elevator rooms, are installed.<br><br>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?<br><br>There were no residents cited in regard to this regulation. | 07/31/2012 |

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| | Room closet did not have a sprinkler head installed. Based on interview at the time of the observations, the Environmental Supervisor acknowledged the Elevator Machine Room in the basement and the Activities Room closet did not have a sprinkler head.<br><br>3.1-19(b)<br>3.1-19(ff) | | How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents, staff and visitors have the potential to be affected by the alleged deficient practice.<br><br>What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br><br>The facility installed a sprinkler head in the elevator room and the activity room closets.<br><br>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>An environmental CQI tool will be utilized weekly x 4 and monthly thereafter to monitor compliance sprinkler heads. The audits are reviewed by the CQI committee and action plans are developed to | |

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| | | | improve performance, which may include reeducation and/or disciplinary action.<br><br>Compliance Date: 7/31/12 | |

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| K0066 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Smoking regulations are adopted and include no less than the following provisions:<br><br>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.<br><br>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.<br><br>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.<br><br>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4<br>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 1 of 1 outside areas where employee smoking was permitted. This deficient practice could affect any staff and visitors in the vicinity of the employee entrance smoking area.<br><br>Findings include:<br><br>Based on observation with the Environmental Supervisor during the tour | K0066 | K066 NFPA 101 Life Safety Code Standard<br><br>It is the policy of this facility to have cigarette butts deposited in a noncombustible container with a self closing lid.<br><br>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice? | 07/31/2012 |

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| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

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| | of the facility on 07/02/12 from 11:30 p.m. to 2:15 p.m., the employee entrance smoking area outside the building had over 100 extinguished cigarette butts on the ground. Based on interview at the time of observation, the Environmental Supervisor acknowledged the facility's employees disposed of cigarette butts on the ground outside at the employee entrance.<br><br>3.1-19(b) | | There were no residents cited in regard to this regulation.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents, staff and visitors have the potential to be affected by the alleged deficient practice.<br><br>What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br><br>A noncombustible container with a self closing lid was placed in the vicinity of the employee entrance smoking area<br><br>Department heads make daily rounds in the facility to monitor environmental safety issues. Employees will be reeducated on the use on safe depositing of cigarette butts. | |

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| | | | How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>An environmental CQI tool will be utilized weekly x 4 and monthly thereafter to monitor compliance with depositing cigarette butts in the proper container. The audits are reviewed by the CQI committee and action plans are developed to improve performance, which may include reeducation and/or disciplinary action.<br><br>Compliance Date: 7/31/12 | |

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| K0130 SS=F | NFPA 101<br>MISCELLANEOUS<br>OTHER LSC DEFICIENCY NOT ON 2786<br>Based on record review, observation and interview; the facility failed to ensure the continuous operation of 75 of 75 battery operated smoke detectors in 75 of 75 resident rooms. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. This deficient practice could affect all 119 residents, staff, and visitors.<br><br>Findings include:<br><br>Based on record review with the Environmental Supervisor from 9:50 a.m. to 11:30 a.m. on 07/02/12, documentation of monthly battery checks for all resident room battery operated smoke detectors was not available for review. Based on interview at the time of record review, the Environmental Supervisor acknowledged there is no documentation of battery checks for resident room smoke detectors to ensure continuous operation. Based on observations with the Environmental Supervisor during the tour of the facility on 07/02/12 from 11:30 p.m. to 2:15 p.m., battery operated smoke detectors were observed in all resident rooms.<br><br>3.1-19(b) | K0130 | K130 NFPA 101 Life Safety Code Miscellaneous<br><br>It is the policy of this facility to ensure the continuous operation of battery operated smoke detectors in resident rooms. In compliance with NFPA 101 4.6.12.2<br><br>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?<br><br>There were no residents cited in regard to this regulation.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents, staff and visitors have the potential to be affected by the alleged deficient practice. | 07/31/2012 |

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| | 3.1-19(ff) | | What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br><br>The facility implemented a log to document the battery checks for smoke detectors in the resident rooms and ensure their continuous operation.<br><br>A new smoke detector was installed in each resident room on or before 7.31.12<br><br>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>The Executive Director will review and audit the documentation monthly to ensure that the battery checks were completed.<br><br>Compliance Date: 7/31/12 | |

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| K0144 SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.<br>3.4.4.1.<br>1. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 52 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Emergency | K0144 | K144 NFPA 101 Life Safety Code Standard<br><br>It is the policy of this facility to inspect the generator weekly and exercise the load for 30 minutes per month in accordance with NFPA 99.<br><br>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?<br><br>There were no residents cited in regard to this regulation.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents, staff and visitors have the potential to be affected | 07/31/2012 |

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| | Generator - Weekly Inspection Checklist" documentation with the Environmental Supervisor during record review from 9:50 a.m. to 11:30 a.m. on 07/02/12, weekly emergency generator starting battery inspection records for 2011 were not available for review and weekly inspection records for the weeks of January 1, 2012 through June 29, 2012 did not document starting battery inspections. Based on interview at the time of record review, the Environmental Supervisor acknowledged weekly emergency generator battery inspection records for twenty five weeks of the thirty one week period of 07/01/11 through 06/29/12 were not available for review.<br><br>3.1-19(b)<br><br>2. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted for 12 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. | | by the alleged deficient practice.<br><br>What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br><br>The facility has implemented documentation for weekly and monthly tests of the generator in accordance with NFPA 99.<br><br>The maintenance director will ensure the weekly tests are ran no more than 7 days a part and that the system iniates within 10 seconds.<br><br>The maintenance director will ensure that the monthly test exercises the load of the generator for 30 minutes.<br><br>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>The Executive Director will review the documentation weekly to | |

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| | Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:<br>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.<br>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.<br>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Emergency Generator - Weekly Exercise/Monthly Load Test Log" documentation with the Environmental Supervisor during record review from 9:50 a.m. to 11:30 a.m. on 07/02/12, monthly load test documentation for 2011 was not available for review and monthly load testing for records for January through June 2012 did not document the duration of each load | | ensure that the generator is tested and meets requirements of NFPA 99. All findings that do not meet requirement will be brought to the CQI governing committee and corrected.<br><br>Compliance Date: 7/31/12 | |

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| | test, the load test percentage of nameplate capacity or the minimum exhaust gas temperatures recommended by the manufacturer. Based on interview at the time of record review, the Environmental Supervisor acknowledged monthly load test documentation for the period of July 2011 through June 2012 was not available for review.<br><br>3.1-19(b)<br><br>3. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Emergency | | | |

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| | Generator - Weekly Exercise/Monthly Load Test Log" documentation with the Environmental Supervisor during record review from 9:50 a.m. to 11:30 a.m. on 07/02/12, monthly load test documentation of emergency power transfer time for 2011 was not available for review and monthly load testing records of emergency power transfer time for January through June 2012 did not document the transfer time from normal electrical power to the emergency generator. Based on interview at the time of record review, the Environmental Supervisor acknowledged monthly load test documentation for emergency power transfer time the period of July 2011 through June 2012 was not available for review.<br><br>3.1-19(b) | | | |

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| K0147 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords was not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect any resident, staff or visitor in the vicinity of the housekeeping room by resident Room 201.<br><br>Findings include:<br><br>Based on observation with the Environmental Supervisor during the tour of the facility on 07/02/12 from 11:30 p.m. to 2:15 p.m., the circulating pump for a natural gas fired water heater in the housekeeping room by resident Room 201 was plugged into an extension cord. Based on interview at the time of observation, the Environmental Supervisor acknowledged the circulating pump for a natural gas fired water heater in the housekeeping room by resident Room 201 was plugged into an extension cord.<br><br>3.1-19(b) | K0147 | K147 NFPA 101 Life Safety Code Standard<br><br>It is the practice of this facility ensure that extension cords are not used as a substitute for fixed wiring.<br><br>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?<br><br>There were no residents cited in regard to this regulation.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents, staff and visitors have the potential to be affected by the alleged deficient practice. | 07/31/2012 |

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| | | | What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br><br>The facility removed the extension cord in room 201 and the gas fired water heater is plugged into an approved fixed wiring outlet.<br><br>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>An environmental CQI tool will be utilized weekly x 4 and monthly thereafter to monitor compliance . The audits are reviewed by the CQI committee and action plans are developed to improve performance, which may include reeducation and/or disciplinary action.<br><br>Compliance Date: 7/31/12 | |

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| K0154 SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1<br><br>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 119 of 119 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Fire Watch Policy | K0154 | K154 NFPA 101 Life Safety Code Standard<br><br>It is the practice of this facility to notify the authority having jurisdiction when the building is without service of an automatic sprinkler system for more than 4 hours in a 24 hour time period. The building will be evacuated of an approved fire watch system will be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to full service. 9.7.6.1<br><br>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?<br><br>There were no residents cited in regard to this regulation. | 07/31/2012 |

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| | and Procedure" documentation with the Environmental Supervisor during record review from 9:50 a.m. to 11:30 a.m. on 07/02/12, Procedure 6 states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the necessary entities, which includes the Indiana State Department of Health, alarm company, local fire department, and building owner/manager, would only be notified in the event of a fire. Based on interview at the time of record review, the Environmental Supervisor acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health, alarm company, local fire department, and building owner/manager in the event the automatic sprinkler system is out of service for four hours or more in a 24 hour period.<br><br>3.1-19(b) | | How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents, staff and visitors have the potential to be affected by the alleged deficient practice.<br><br>What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br><br>The Beech Grove Meadows Fire Watch policy has been updated to include notification of the Indiana State Department of Health, the fire department, the Fire Alarm Company, building owner, and insurance carrier in the event of a sprinkler system failure.<br><br>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? | |

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| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | The fire watch policy will be reviewed annually by the CQI team in accordance with the Disaster Plan review.<br><br>Compliance Date: 7/31/12 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 07/02/2012 |

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| K0155 SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8<br><br>Based on record review and staff interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 119 of 119 residents. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Fire Watch Policy and Procedure" documentation with the Environmental Supervisor during record review from 9:50 a.m. to 11:30 a.m. on 07/02/12, Procedure 6 states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the authority having jurisdiction, the Indiana State Department of Health, would only be notified in the event of a fire. Based on interview at the | K0155 | K155 NFPA 101 Life Safety Code Standard<br><br>It is the practice of this facility to notify the authority having jurisdiction when the building is without service of the fire alarm system for more than 4 hours in a 24 hour time period. The building will be evacuated of an approved fire watch system will be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to full service. 9.6.1.8.<br><br>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?<br><br>There were no residents cited in regard to this regulation. | 07/31/2012 |

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| | time of record review, the Environmental Supervisor acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health would occur in the event the fire alarm system is out of service for four hours or more in a 24 hour period.<br><br>3.1-19(b)) | | How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents, staff and visitors have the potential to be affected by the alleged deficient practice.<br><br>What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br><br>The Beech Grove Meadows Fire Watch policy has been updated to include notification of the Indiana State Department of Health of a fire alarm system failure.<br><br>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>The fire watch policy will be reviewed annually by the CQI team in accordance with the | |

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| | | | Disaster Plan review.<br><br>Compliance Date: 7/31/12 | |